

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/17/2012
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	INITIAL COMMENTS A revisit to KY #17858 was conducted in conjunction with the recertification survey on 05/14/12 through 05/17/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S being "G." A separate CMS 2567 will be issued for the recertification survey; however, that document will contain Event ID EY1711, detailing the same tags at F225, F226, F241, F490 and F520.	{F 000}	Preparation and execution of this plan of Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	<u>F 225 (G) INVESTIGATE/REPORT/ALLEGATIONS</u> <i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a witness to the reporting of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>06/11/2012</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and review of the facility's Incident/Investigative Report, it was determined the facility failed to ensure all alleged violations were reported in accordance with State and Federal regulations; failed to provide evidence that an alleged violation was thoroughly investigated; and failed to prevent further potential abuse for one resident (#5), in the selected sample of 19 residents. The facility failed to follow their investigation and Abuse policy/procedure. Resident #5 reported an allegation of verbal abuse to Certified Medication Technician (CMT) #2, witnessed by CMT #3 (refer to F241) on 04/28/12. While the CMTs notified the Administrative nurse, the facility continued to allow the alleged perpetrator, Nurse Aide State Registered (NASR) #5, to give direct care to other residents to include bathing the victim, prior to removing the perpetrator for over an hour after the allegation was made. On 05/15/12, eighteen (18) days after the incident, Resident #5 was</p>	F 225	<p>Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 225. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to allegations of abuse.</p> <p><i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the revision of policies as they relate to investigation and reporting of allegations of abuse. A newly revised Abuse Prohibition and Control Manual was developed and implemented on June 1, 2012. The QAA Committee approved the revised policies for Abuse</p>		

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F 226	<p>Continued From page 2</p> <p>observed crying while describing the incident stating it embarrassed him/her and made him/her feel bad. The facility's investigation was not thorough as all witnesses, staff nor the victim were interviewed. Additionally, the facility failed to report the allegation to the State Agency.</p> <p>Findings Include:</p> <p>A review of the facility's Investigation policy/procedure, revised 02/26/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-interview the alleged resident or victim; interview witnesses to include the assigned caregiver, caregivers in the immediate area, remote or potential witnesses; and interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established.</p> <p>A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation</p>	F 226	<p>Prohibition and Control on May 31, 2012.</p> <p>The Administrator conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse Prohibition and Control Manual policies that includes what to do immediately following an allegation of abuse. A Post Test for employees was held on these same dates on how and when to report any allegations of abuse.</p> <p>Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns regarding the investigating and reporting of abuse allegations and to solicit dignity concerns. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding dignity, abuse investigation and reporting of allegations.</p> <p><i>Monitoring</i></p> <p>The Administrator will review all allegations of abuse with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that allegations of abuse are investigated and reported immediately.</p> <p>The QAA Committee will meet weekly beginning May 31, 2012 for a</p>		

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F 226	<p>Continued From page 3 and report the results of the investigation within five working days to the Division of Long-Term Care.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact.</p> <p>A review of the facility's Incident/Investigation Report, dated 04/28/12, revealed an allegation was made by Resident #5 to Certified Medication Tech (CMT) #2. CMT #2 reported the allegation to Licensed Practical Nurse (LPN) #8. Allegedly, Nurse Aide State Registered (NASR) #5 stated that the way the resident drank water reminded her of her "dog." According to the investigation, the comment was made on 04/27/12, during a meal. The investigation included a statement by NASR #5, dated 04/28/12, indicating, that on 04/27/12, she was feeding Resident #5 in the dining room. There were other residents and family members present at the table. She was talking to the resident about her "puppy" and she made a comment that the resident nodded his/her head like her "puppy." NASR #5 indicated in the statement, she did not mean to hurt the resident's feelings. There were no other written statements included in the investigation. The Administrator's Report (included in the investigation), dated 04/28/12, revealed NASR #5 was suspended after the report was made to LPN #8. It further revealed Resident #5 was "extremely sensitive" about the progression of his/her ALS and the resident was noted to cry at</p>	F 226	<p>minimum of four weeks and until regulatory compliance is achieved. All allegations of Abuse will be submitted to the QAA Committee by the Social Services Director and reviewed by the QAA Committee to determine that all allegations of abuse are investigated and reported immediately to the Administrator, Social Services Director, Director of Nursing and all regulatory reporting agencies.</p> <p>Completion Date: June 20, 2012</p> <p><u>F 226 (G) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</u></p> <p><i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a witness to the reporting of Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and</p>	06/20/12	

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F 226	<p>Continued From page 4</p> <p>various times about his/her loss of function. The Administrator interviewed three other residents in the facility with no complaints, and indicated that Resident #5 was very sensitive about ALS and his/her health, but there was no crying noted during the Administrator's interview with the resident. That concluded the investigation. There was no evidence the facility substantiated/unsubstantiated the incident.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM and 06/16/12 at 2:10 PM, revealed he/she was fed by staff due to a recent decline related to the disease process of ALS. The resident revealed it was going to get worse and he/she was discouraged with the loss of independence. The resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during the resident interview, on 05/15/12 at 4:15 PM, revealed Resident #5 was visibly upset and crying while discussing the comment made by NASR #5, on 04/27/12.</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to</p>	F 225	<p>post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 226. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to allegations of abuse.</p> <p><i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the revision of policies as they relate to the prevention of mistreatment, neglect and abuse. A newly revised Abuse Prohibition and Control Manual was developed and implemented on June 1, 2012. The QAA Committee approved the revised policies for Abuse Prohibition and Control on May 31, 2012.</p>		

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F 225	<p>Continued From page 5</p> <p>LPN #8. After reporting, LPN #8 made a phone call in her office, so he went to lunch with CMT #3. He did not know when NASR #5 was removed from resident care.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the resident's allegation reported to CMT #2. She revealed CMT #2 left the resident's room to report the allegation to LPN #8. CMT #3 left the resident's room shortly after, and went to LPN #8's office. She went to lunch with CMT #2 after the report was made. She revealed NASR #5 had been preparing to give the resident a shower, but she "assumed" it was not given by her, as this was an allegation of verbal abuse. She did not know when NASR #5 was removed from care. A review of the Timecard Report for CMT #2 and CMT #3, dated 04/28/12, revealed both employees clocked out for lunch at 10:31 AM.</p> <p>An interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she gave Resident #5 a shower and provided Incontinent care for another resident, on 04/28/12, prior to her suspension. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM; at least one hour and fifteen minutes after the allegation was reported to LPN #8.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed she was the Administrative Licensed Nurse in the facility, on 04/28/12. The allegation of verbal abuse was reported to her by CMT #2. She revealed when she went to find NASR #5, she was giving a resident a shower. She stated that everyone on the floor was "busy",</p>	F 225	<p>The Administrator conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse Prohibition and Control Manual policies that includes policies related to mistreatment, neglect, and abuse. A Post Test for employees was held on these same dates on the prevention of mistreatment, neglect, and abuse.</p> <p>Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns regarding the mistreatment, neglect, and abuse policies. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding mistreatment, neglect, and abuse policies.</p> <p>Monitoring The Administrator will review all allegations of abuse with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that the developed and implemented policies to prevent mistreatment, neglect, and abuse are being followed.</p> <p>All allegations of mistreatment, neglect and abuse will be submitted to the QAA Committee by the Social</p>		

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F 225	<p>Continued From page 6</p> <p>so she reported to the charge nurse to send NASR #5 to her office when she was finished with the resident's shower. She did not know which resident was in the shower room with NASR #5. She admitted she should have removed NASR #5 from resident care immediately, per the facility policy. LPN #8 revealed she did not conduct a thorough investigation. She did not document a statement from Resident #5. She also revealed she should have obtained statements from CMT #2 and GMT #3. She did not verify who was sitting at the table when the comment was made to the resident, and did not try to contact any of them. She stated it was "very busy" that morning.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed LPN #8 contacted her at home, on 04/28/12, to report the allegation. She revealed LPN #8 was instructed to gather statements from anyone around the area, any resident that could have heard the comment, and any residents cared for by NASR #5. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately. She stated she did not speak to Resident #5 about the allegation.</p> <p>An interview with the Social Services Director, on 05/17/12 at 9:10 AM and 3:00 PM, revealed she was the facility's abuse coordinator; however, she was not aware of the allegation made by Resident #5.</p> <p>An interview with the Administrator, on 05/14/12 at 4:00 PM and 06/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the</p>	F 225	<p>Services Director and reviewed by the QAA Committee to determine that these allegations are being treated according to the policies of the facility</p> <p>The QAA Committee will meet weekly to address policies relating to the prevention of mistreatment, neglect and abuse beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved.</p> <p>Completion Date: June 20, 2012</p> <p><u>F 241 (G) DIGNITY AND RESPECT OF INDIVIDUALITY</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #8 who is a Licensed Practical Nurse was educated on the</p>	6/20/12	

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F 225	Continued From page 7 resident was not upset about the comment; however, she admitted she did not question the resident about what happened. The Administrator revealed the investigation did not have enough information to determine the findings of the allegation; however, it was discussed in the Quality Assurance (QA) committee meeting, on 04/28/12, with no concerns. She revealed the Social Services Director was responsible for ensuring a thorough investigation, with assistance from the DON and Administrator. She revealed the allegation was not reported to the State Agency, as it did not qualify as verbal abuse. NASR #5 was terminated due to the "questionable" incident. An interview with the Corporate Compliance Nurse, on 05/17/12 at 5:00 PM, revealed he did review the investigation in the QA committee meeting, on 04/30/12. The allegation was unsubstantiated due to the statement by NASR #5; however, he admitted it was not a thorough investigation to determine the findings of the allegation. He could not recall if he recommended a more thorough investigation after review, on 04/30/12. He revealed the facility did not report the allegation because the allegation was unsubstantiated. He stated that any allegation of abuse would be reported to the State Agency; however, he did not feel this was verbal abuse.	F 226	facility Dignity policy and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 241. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to care and treatment that includes dignity. <i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the guidance of policy as it relates to Dignity. The facility Dignity Policy was revised on May 31, 2012 and approved by the QAA Committee on that date. The policy was implemented on June 1, 2012, and educated to all staff by the Administrator on June 1-6, 2012. A new policy on "How to Converse With Residents" was developed on May 31, 2012 and approved by the QAA Committee on that date. The		
(F 226) SS=G	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	(F 226)			

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{F 226}	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to implement written policies and procedures that prohibit abuse of residents for one resident (#5), in the selected sample of 19 residents. The facility failed to implement the Investigation and Abuse policy/procedure as evidenced by the failure to protect Resident #5 after an allegation of verbal abuse. Resident #5 reported an allegation of verbal abuse to Certified Medication Technician (CMT) #2, witnessed by CMT #3 (refer to F241) on 04/28/12. While the CMTs notified the Administrative nurse, the facility continued to allow the alleged perpetrator, Nurse Aide State Registered (NASR) #5, to give direct care to other residents to include bathing the victim, prior to removing the perpetrator for over an hour after the allegation was made. On 05/15/12, eighteen (18) days after the incident, Resident #5 was observed crying while describing the incident stating it embarrassed him/her and made him/her feel bad. The facility's investigation was not thorough as all witnesses, staff nor the victim were interviewed. Findings Include: A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee.	{F 226}	policy was implemented on June 1, 2012, and educated to all staff by the Administrator on June 1-6, 2012. Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns related to dignity. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding dignity. <i>Monitoring</i> All concerns from any source regarding dignity will be submitted to the Social Services Director. The Administrator will review all dignity concerns with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that the developed and implemented dignity policies are being followed. The Administrator and Social Services Director will submit all dignity concerns to the QAA Committee. The QAA Committee will meet weekly to address policies relating to the prevention of mistreatment, neglect and abuse beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved.		

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	<p>Continued From page 9</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact.</p> <p>An interview with Resident #5, on 05/16/12 at 4:15 PM and 05/16/12 at 2:10 PM, revealed he/she had to be fed by the staff due to a recent decline related to the disease process of ALS. The resident revealed it was going to get worse and he/she was discouraged with the loss of independence. The resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during the resident interview, on 05/16/12 at 4:15 PM, revealed Resident #5 was visibly upset and crying while discussing the comment made by NASR #5, on 04/27/12.</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 was in his/her room, on 04/28/12, visibly upset and crying. He revealed the resident expressed a complaint about having to get a shower so late in the morning. During conversation with Resident #5 while providing care, the resident stated "they probably would not</p>	{F 226}	<p>Completion Date: June 20, 2012</p> <p><u>F 490 (G) EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated by the Administrator and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a witness to the reporting of Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012 by the Administrator. Additionally a formal counseling was completed with employee #8 on June 5, 2012 by the Administrator.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i></p>	6/20/12

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{F 226}	<p>Continued From page 10</p> <p>listen because apparently he/she looked like a dog." He revealed upon discussion with the resident, it was reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to Licensed Practical Nurse (LPN) #8 and left for lunch.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the resident's allegation reported to CMT #2. She stated that NASR #5 was in the room, but left to get towels for the resident's shower. She revealed the resident stated that he/she did not like NASR #5 because of the comment made, on 04/27/12. She revealed CMT #2 left the room to report the allegation to LPN #8. After the report was made, she left for lunch with CMT #2. She revealed NASR #5 was preparing to give the resident a shower, but she "assumed" it was not given by her. She did not know when NASR #5 was removed from resident care.</p> <p>An interview with NASR #6, on 05/17/12 at 11:45 PM, revealed NASR #5 gave Resident #5 a shower, on 04/28/12, prior to her suspension.</p> <p>An interview with NASR #5, on 06/16/12 at 3:45 PM, revealed she gave Resident #5 a shower and provided incontinent care for another resident, on 04/28/12, prior to her suspension. A review of the Timecard Report for CMT #2 and CMT #3, dated 04/28/12, revealed both employees clocked out for lunch at 10:31 AM. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM, at least one hour and fifteen minutes after the allegation was reported to LPN #8.</p>	{F 226}	<p>All residents have the potential to be affected by F 490. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. The Administrator instructed nursing staff on second shift to complete interviews with all residents on June 5-6, 2012 to solicit any concerns relating to dignity, mistreatment, neglect and abuse.</p> <p><i>Systemic Changes</i> On May 29, 2012 the Administrator contracted with an experienced skilled nursing facility consultant to re-educate her in the areas of Abuse Prohibition and Control that includes investigating and reporting of allegations, development and implementation of policies related to mistreatment, neglect and abuse; Dignity; and Quality Assessment and Assurance programming.</p> <p>The Administrator has inserviced all staff on Abuse Prohibition and Control that includes investigating and reporting of allegations, development and implementation of policies related to mistreatment, neglect and abuse; Dignity; (June 1-4, 2012) and Quality Assessment and Assurance programming (June 5-7, 2012).</p> <p>The Administrator initiated that Resident Council meetings will be</p>		

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(F 226)	<p>Continued From page 11</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2 (right before he left for lunch). She revealed she went to find NASR #5; however, she was giving a resident a shower. She stated that everyone on the floor was "busy", so she reported to the charge nurse to send NASR #5 to her office when she was finished with the shower. She did not know which resident was in the shower room with NASR #5. She admitted she should have removed NASR #5 from resident care immediately, per the facility's policy.</p> <p>An interview with LPN #3, on 05/16/12 at 10:05 AM, revealed she was the charge nurse, on 04/28/12, and was aware of the allegation made against NASR #5. She stated that LPN #8 asked her to send NASR #5 to her office after completing care for a resident in the shower room. She admitted she was making "rounds" and providing care for other residents; therefore, she was not monitoring the shower room to ensure NASR #5 went to see LPN #8. She revealed NASR #5 should have been sent home immediately, but LPN #8 was in charge as the Administrative Licensed Nurse on duty.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed she was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately, removing her from care of any residents.</p> <p>An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was not aware NASR</p>	(F 226)	<p>held every week beginning June 1, 2012 to solicit any concerns regarding the investigating and reporting of abuse allegations, to solicit any concerns regarding mistreatment, neglect/abuse and to solicit any concerns with dignity. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding abuse allegations, abuse policies and dignity.</p> <p>A newly created position was developed by the Administrator on May 29, 2012 that included a Job Description for a facility Quality Assurance (QA) Nurse. The QA Nurse will complete detailed reviews and adherence of policies in the facility of areas identified through the Continuous Quality Improvement Committee, the Administrator and other staff members.</p> <p>The Administrator initiated a review of the Quality Assurance and Assessment (QAA) Committee and the QAA policies that have been reviewed and revised on May 31, 2012 to better identify and address quality issues on a more immediate basis.</p> <p>The Interdisciplinary Team (IDT) was educated by the Administrator on June 5, 2012 on the newly</p>	

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{F 226} F 241 SS=G	Continued From page 12 #5 provided care to Resident #5, prior to her suspension. She expected LPN #8 to find another caregiver to take over for NASR #5. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that enhanced each resident's dignity and respect for one resident (#5), in the selected sample of 19 residents. The facility failed to follow the Dignity/Respect policy. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 allegedly made a comment that the resident was drinking his/her water similar to her "dog." Resident #5 reported the comment to the staff, on 04/28/12; however, NASR #5 was allowed to continue providing care for Resident #5. An interview with Resident #5, on 06/16/12 at 4:15 PM, revealed the resident did not want NASR #5 providing his/her care. The resident revealed the comment was embarrassing and made him/her "feel bad." Resident #5 was visibly upset and crying during the interview with the surveyor, 18 days after the incident. Findings include:	{F 226} F 241	developed Continuous Quality Improvement (CQI) Investigation system. The newly developed CQI Investigation system was implemented on June 7, 2012 by the Administrator and all staff educated on this same date. The CQI investigation system is designed for the participation of all employees. The Administrator conducted training on June 5, 2012 to the IDT team and all other staff on June 8, 2012 to educate all staff on the QAA policies, committee structure, and how to involve themselves in the QAA process. A Post Test for QAA was administered to staff on June 8, 2012. The facility conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse and Dignity policies. A Post Test for Abuse and Dignity was conducted on these same dates. <i>Monitoring</i> The newly hired skilled nursing facility consultant will make routine visits to review sustained compliance with Abuse Prohibition and Control and Quality Assurance and Assessment programs for a minimum of three months. The Quality Assurance and Assessment Committee will review with the Administrator the submitted		

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 428 ISLAND FORD ROAD MADISONVILLE, KY 42431
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F 241	<p>Continued From page 13</p> <p>A review of the facility's Dignity/Respect policy, revised 10/04/11, revealed appropriate measures would be taken to assure the residents were treated in a courteous and dignified manner. The staff would promote independence and dignity in dining.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact and able to eat independently with tray setup. A review of the Activities of Daily Living (ADL) Tracking record, dated March 2012 and April 2012, revealed a decline in the resident's eating abilities, requiring extensive to total assistance for eating after 03/27/12.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM, and on 05/16/12 at 2:10 PM, revealed he/she was fed by the staff due to a recent decline related to the disease process of ALS. The resident revealed it was going to get worse and he/she was discouraged with the loss of independence. The resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the</p>	F 241	<p>reports from the Quality Assurance Nurse and the Social Services Director for a minimum of three months or until compliance is sustained.</p> <p>Completion Date: June 20, 2012</p> <p><u>F 520 (G) QAA COMMITTEE MEMBERS/ MEET</u></p> <p><i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012. Additionally a formal counseling was</p>	6/20/12
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F 241	<p>Continued From page 14</p> <p>report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during a resident interview, on 05/16/12 at 4:15 PM, revealed Resident #5 was visibly upset and crying while discussing a comment made by NASR #5, on 04/27/12, 18 days after the incident.</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 was in his/her room, on 04/28/12, visibly upset and crying. He revealed the resident expressed a complaint about having to get a shower so late in the morning. He revealed the resident wanted to get up at 9:00 AM, and it was almost 11:00 AM. CMT #2 told the resident he would report it to the charge nurse; however, the resident stated "they probably would not listen because apparently he/she looked like a dog." He revealed upon discussion with the resident, it was reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to Licensed Practical Nurse (LPN) #8.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the allegation reported to CMT #2. She revealed the resident was upset and crying when she went into the room. She stated that NASR #5 was in the room, but left to get towels for the resident's shower. She revealed the resident stated that he/she did not like NASR #5 because of the comment made, on 04/27/12. She revealed NASR #5 was preparing to give the resident a shower, but she "assumed" it was not given by her, as this was an allegation of verbal abuse.</p> <p>An interview with NASR #6, on 05/17/12 at 11:45 PM, revealed NASR #5 gave Resident #5 a</p>	F 241	<p>completed with employee #8 on June 5, 2012.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 520. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p> <p><i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the facility in the areas of Abuse Prohibition and Control and Quality Assessment and Assurance programs.</p> <p>A newly created position was developed by the Administrator on May 29, 2012 that included a Job Description for a facility Quality Assurance (QA) Nurse. The QA Nurse will complete detailed reviews and adherence of policies in the facility of areas identified through the Continuous Quality Improvement Committee, the Administrator and other staff members.</p> <p>A review of the Quality Assurance and Assessment (QAA) Committee and the QAA policies have been reviewed and revised on May 31, 2012 to better identify and address</p>		

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F 241	<p>Continued From page 15</p> <p>shower, on 04/28/12. She revealed NASR #5 needed assistance with the resident after the shower, but she and another NASR took over while NASR #5 went to assist another resident. She revealed the resident began talking about the comment made by NASR #5 and appeared to be upset.</p> <p>An interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she was feeding Resident #5 in the dining room, on 04/27/12, and they were talking about her "puppy." She revealed the resident nodded his/her head to drink and the comment was made "that was how my puppy nods its head." NASR #5 admitted she gave the resident a shower, on 04/28/12, prior to her suspension.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, on 05/16/12 at 2:35 PM, and on 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2. She revealed she went to find NASR #5; however, she was giving a resident a shower. She stated that everyone on the floor was "busy", so she reported to the charge nurse to send NASR #5 to her office when she was finished with the resident's shower. She did not know which resident was in the shower room with NASR #5. LPN #8 revealed when questioning Resident #5 about the allegation, the resident was quiet and had "one tear" roll down his/her face.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed she did not speak to Resident #5 about the allegation. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8.</p>	F 241	<p>quality issues on a more immediate basis. The QAA Committee structure has been changed to include the Medical Director, Quality Assurance Nurse, Administrator, Director of Nursing, Social Services Director, Corporate Compliance Officer, and Infection Disease Control Preventionist.</p> <p>The Interdisciplinary Team (IDT) was educated on June 5, 2012 on the newly developed Continuous Quality Improvement (CQI) Investigation system. The newly developed CQI Investigation system was implemented on June 7, 2012 and all staff educated on this same date. The CQI investigation system is designed for the participation of all employees.</p> <p>The facility conducted training on June 5, 2012 to the IDT team and all other staff on June 8, 2012 to educate all staff on the QAA policies, committee structure, and how to involve themselves in the QAA process. A Post Test for QAA was administered to staff on June 8, 2012. The facility conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse and Dignity policies. A Post Test for Abuse and Dignity was conducted on these same dates.</p> <p><i>Monitoring</i></p>		

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F 241	Continued From page 16 An interview with the Social Services Director, on 06/17/12 at 9:10 AM and 3:00 PM, revealed she was not aware of the allegation made by Resident #5. She revealed she spoke to the resident about his/her diagnosis of ALS and to see if there was any depression; however, she was not asked to speak to the resident about an allegation of abuse. She revealed she did not recall the discussion about the allegation in the QA meeting, held on 04/30/12. An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the resident was not upset about the comment; however, she admitted she did not question the resident about what happened or ask the resident how the comment made him/her feel.	F 241	The QAA Committee approved the revised policies for Abuse Prohibition and Control and Quality Assessment and Assurance on May 31, 2012. The QAA Committee will meet weekly beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved. The Quality Assurance Nurse will submit findings of all clinical reviews to the QAA Committee meeting for recommendations and follow-up. All allegations of Abuse will be submitted to the QAA Committee by the Social Services Director and reviewed by the QAA Committee for recommendations and follow-up. Completion Date: June 20, 2012	6/20/12
{F 490} SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure, and review of the facility's Incident/Investigation Report, it was determined the facility failed to be administered in a manner that enabled it to use its resources	{F 490}		

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 490}	<p>Continued From page 17</p> <p>effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one resident (#5), in the selected sample of 19 residents.</p> <p>The facility failed to follow the "Abuse, Neglect, and Exploitation" policy/procedure related to the protection of residents, investigation, and reporting of an allegation of abuse. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 made a comment that the resident was drinking his/her water similar to her "dog." Resident #5 reported the comment to the staff, on 04/28/12; however, the facility allowed NASR #5 to continue to provide care to Resident #5 and other residents for at least one hour and fifteen minutes, prior to suspension. An interview with Resident #5, on 05/15/12 at 4:15 PM, revealed the resident did not want NASR #5 providing his/her care. The resident revealed the comment was embarrassing and made him/her "feel bad." Resident #5 was visibly upset and crying during the interview, 18 days after the incident (refer to F241). Licensed Practical Nurse (LPN) #8 failed to conduct a thorough investigation of the allegation and remove NASR #5 from resident care immediately.</p> <p>The allegation was discussed in the morning Quality Assurance (QA) committee meeting, on 04/30/12; however, these issues were not identified as a problem. Additionally, the Administrator failed to report the allegation of abuse to the State Agency (refer to F225 and F226).</p>	{F 490}			

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(F 490)	Continued From page 18 Findings include: A review of the facility's Investigation policy/procedure, revised 02/25/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-Interview the alleged resident or victim; interview witnesses to include the assigned caregiver, caregivers in the immediate area, remote or potential witnesses; and interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established. A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation and report the results of the investigation within five working days to the Division of Long-Term Care. A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS).	(F 490)			

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{F 490}	<p>Continued From page 19 Anxiety, and Depressive Disorder.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM, and on 05/16/12 at 2:10 PM, revealed the resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower.</p> <p>Interviews with CMT #2 and CMT #3, on 05/16/12 at 9:32 AM and 10:35 AM, respectively, confirmed the resident's allegation and that it was reported to LPN #8 as an allegation of verbal abuse. CMT #3 revealed the resident was upset and crying. An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the resident was quiet and had "one tear" roll down his/her face.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2. NASR #5 was giving a resident a shower. She confirmed she did not remove NASR #5 from direct care immediately. She admitted she should have removed NASR #5 from resident care immediately, per the policy. LPN #8 further revealed she did not conduct a thorough investigation. She did not document a</p>	{F 490}			

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{F 490}	<p>Continued From page 20</p> <p>statement from Resident #5. She also revealed she should have obtained statements from CMT #2 and CMT #3. She did not verify who was sitting at the table when the comment was made to the resident, and did not try and contact any of them. She also indicated that the investigation was turned over to the Administrator and reviewed in the QA committee meeting; therefore, they should have ensured the investigation was completed.</p> <p>A review of the Timecard Report for CMT #2 and CMT #3, dated 04/28/12, revealed both employees clocked out for lunch at 10:31 AM. A review of the facility's Incident/Investigation Report, dated 04/28/12, revealed a written statement by NASR #5; however, there were no other statements included in the investigation. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM, at least one hour and fifteen minutes after the allegation was reported to LPN #8. An interview with NASR #5, on 05/16/12 at 3:46 PM, revealed she gave Resident #5 a shower and provided incontinent care for another resident on 04/28/12, prior to her suspension.</p> <p>An Interview with the Director of Nursing (DON), on 05/17/12 at 2:36 PM, revealed LPN #8 contacted her at home, on 04/28/12, to report the allegation. She revealed LPN #8 was instructed to gather statements from anyone around the area, from any resident that could have heard the comment, and from residents cared for by NASR #5. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately. She did not</p>	{F 490}		

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{F 490}	<p>Continued From page 21 speak to the resident about the allegation.</p> <p>An interview with the Social Services Director, on 05/17/12 at 9:10 AM and 3:00 PM, revealed she was the facility's abuse coordinator. She was not knowledgeable of the facility's policy/procedure related to abuse/neglect. She revealed if allegations of abuse/neglect were unsubstantiated, they were not reported to the State Agency. She was not aware of the allegation made by Resident #5; however, she attended the Quality Assurance (QA) committee meeting (where the investigation was discussed), on 04/30/12.</p> <p>An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the resident was not upset about the comment; however, she admitted she did not question the resident about what happened. The Administrator revealed the investigation did not have enough information to determine the findings of the allegation. She revealed Social Services was responsible for ensuring a thorough investigation, with assistance from the DON and Administrator. She further verified it was discussed in the QA committee meeting, on 04/30/12, with no concerns. She revealed the allegation was not reported to the State Agency, as it did not qualify as verbal abuse.</p> <p>An interview with the Corporate Compliance Nurse, on 05/17/12 at 5:00 PM, revealed he did review the investigation in the QA committee meeting, on 04/30/12. The allegation was unsubstantiated due to the statement by NASR #5; however, he admitted it was not a thorough</p>	{F 490}			

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{F 490}	Continued From page 22 Investigation to determine the findings of the allegation. He could not recall if he recommended a more thorough investigation after review, on 04/30/12. He revealed the facility did not report to the State Agency because the allegation was unsubstantiated. He stated that any allegation of abuse would be reported; however, he did not feel this was verbal abuse. However, interview with CMT #3 revealed this was an allegation of abuse.	{F 490}			
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520			

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F 520	Continued From page 23 This REQUIREMENT Is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and Plan of Correction, it was determined the facility's Quality Assessment and Assurance Program failed to follow their Plan of Correction related to the implementation of an appropriate plan of action related to an investigation involving care and services of one resident (#5), in the selected sample of 19 residents. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 allegedly made a comment that the resident was drinking his/her water similar to her "dog." The comment was reported by Resident #5 to Certified Medication Tech (CMT) #2 on Saturday, 04/28/12. CMT #2 reported the allegation to Licensed Practical Nurse (LPN) #8, who was the Administrative Licensed Nurse on duty. LPN #8 failed to remove NASR #5 immediately from resident care. NASR #5 was allowed to work at least one hour and fifteen minutes after the allegation was reported. LPN #8 failed to conduct a thorough investigation to determine the findings of the allegation. The facility's Incident Investigation Report contained one statement only, from the alleged perpetrator. The Administrator was made aware of the allegation, on 04/28/12; however, could not provide evidence that she notified the Registered Nurse (RN) Corporate Compliance Nurse immediately. The investigation was discussed in the Quality Assurance and Assessment (QAA) Committee meeting, on 04/30/12; however, there were no issues identified related to the investigation. The investigation was determined	F 520			

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F 520	<p>Continued From page 24</p> <p>as unsubstantiated, on 04/30/12, and the allegation was not reported to the State Agency. NASR #5 was terminated on 05/07/12 due to misconduct.</p> <p>Refer to (F225, F226, F241, and F490)</p> <p>Findings include:</p> <p>A review of the facility's Investigation policy/procedure, revised 02/25/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-Interview the alleged resident or victim; Interview witnesses to include the assigned caregiver, caregivers in the immediate area, remote or potential witnesses; and Interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established.</p> <p>A review of the facility's Continuous Quality Improvement Program policy/procedure, revised 03/30/10, revealed monitoring and evaluation of resident care and services with a focus on continuous improvement were the fundamental activities of any quality improvement process.</p> <p>A review of the facility's Abuse, Neglect, and</p>	F 520			

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F 520	<p>Continued From page 25</p> <p>Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation and report the results of the investigation within five working days to the Division of Long-Term Care.</p> <p>A review of the facility's inservice sign-in sheet for "Investigation of Incident", dated 02/17/12, revealed LPN #8, the Administrator, and RN Corporate Compliance Nurse attended the inservice.</p> <p>A review of the facility's Plan of Correction, compliance date 03/11/12, revealed Licensed Administrative Staff would be appointed on a rotating basis to provide four hours of on-site supervision on weekends. The Licensed Administrative Staff would report any neglect investigation reports or issues involving care and services to the Administrator and DON. The Plan of Correction further revealed "In the event that an occurrence would be noted on the rotating weekend rounds, the Administrator would be notified immediately who would immediately notify the RN Corporate Compliance Nurse. An evidence based investigation would be conducted and all appropriate agencies, family, Medical Doctor (MD) notified." "Findings from the weekend rotations of Licensed Administrative Staff were reported to the Interdisciplinary Team (IDT)/QA Committee on Monday so that any investigations could be discussed and appropriate action could be taken.</p>	F 520		